Open Enrollment Guide For Plan Year 2009

Seattle Police Officers' Guild

October 1 - October 30, 2008

2009 plan enhancements start on page 4!

City of Seattle
Personnel Department

Letter from Mark M. McDermott, Personnel Director

Fall 2008

Dear Members of the Seattle Police Officers' Guild:

Open Enrollment is your opportunity to familiarize yourself with changes occurring to your benefit plans and to make changes to your benefits for the coming year. Please read through this Guide to familiarize yourself with benefits changes before you make choices for 2009. The City's Open Enrollment period this year is **October 1 – 30, 2008.** All changes you make during this time will be effective January 1, 2009.

Enhancements for 2009 include adding a full disease management program, voluntary personal health assessment, a personal health record, and 24-hour nurse consultation for the Traditional and Preventive plans. If you (re)enroll in the health care flexible spending account (FSA) program, you will have an additional way to access your funds for eligible expenses by using a dedicated debit card.

Please note the **eligibility age for dependent children will increase to age 25** (through age 24) on all plans regardless of whether they are in school. **If your child was not eligible in 2008 and will meet the new eligibility requirement, be sure to enroll him/her on your plans.** Read the Plan Changes section of the Guide (pp 4-7) for more benefits change information.

Please take the next few weeks to review your family's medical and other insurance needs so that you can update your coverage appropriately during open enrollment. Benefits staff and plan providers will be available to answer questions at the benefits fairs held during the month of October. If you do not make any changes, your current coverage will continue in 2009, except with regard to the FSA. If you want to continue having a Flexible Spending Account, you must re-enroll by law.

Sincerely,

Mark M. McDermott
Personnel Director

If you have difficulty understanding the information in this Guide

Help is available if you have trouble reading or understanding this Guide. If the problem you have is not addressed below, please call the City Benefits Unit at 206-615-1340 so we can provide the assistance you need.

- **English is Your Second Language?** If English is not your native language, translators are available to help you. Many City employees have volunteered to translate for fellow employees. To find someone who speaks your language click here http://inweb/LanguageBank/LB_Lookup.asp . Inside the light blue box, click the arrow next to the white box and find the language you speak. Then click the GO button. You will find a list of employees who speak that language. If the "Translate" box contains a "Y," that person will translate for you. Call and find a time he/she is available; make an appointment with the City Benefits Unit (206-615-1340) and bring that person with you. Together we'll help you understand your City benefits.

  If you do not have access to a computer, ask your Department's HR/Benefits representative to help you, or call the Benefits Unit at 206-615-1340.

- **Hearing Impaired?** If you use a TDD, the City provides translation services. Call 7-1-1 or 1-800-833-6384 on your TDD. You will be connected with the Washington Relay Service. Give them the number of the party you wish to call. They will call the person for you, then translate information from your TDD to the person you are calling.

- **Visually Impaired?** This Guide is available in a larger font. To request an electronic copy, contact the Benefits Unit at 206-615-1340.

- **Would rather *hear* the information than *read* it?** If your understanding is improved by having someone read or paraphrase information for you, you are invited to attend a benefits orientation. Orientations cover all City Benefits and provide ample time for questions. You can meet with the presenter after the session if you have questions you would like to ask confidentially. Orientations are held every week - call 206-615-1340 to sign up.

If you have further questions or concerns or would like to speak to someone confidentially, call the Benefits Unit (206-615-1340).

In This Guide

Checklist of Changes You Can Make During Open Enrollment

Higher Age Limit on Health Care Plans for Dependent Children

Please note eligibility age limit is being **increased** to age 25 (through age 24) for unmarried, dependent children regardless of whether they are in school, but you must **enroll them during open enrollment** to take advantage of this extension.

- ☐ Add your under age 25 dependent(s)

Medical coverage

- ☐ Change to a different plan
- ☐ Add a family member
- ☐ Drop a family member

Dental coverage

- ☐ Change to a different plan
- ☐ Add a family member
- ☐ Drop a family member

Vision coverage

- ☐ Add a family member
- ☐ Drop a family member

Supplemental Long Term Disability coverage

- ☐ Enroll in Supplemental LTD
- ☐ Drop Supplemental LTD

Life insurance (Medical History Statement required if adding or increasing coverage)

- ☐ Change beneficiary designation
- ☐ Add Basic Life or Limited Basic Life coverage
- ☐ Change your Basic Life to Limited Basic Life (or vice versa)
- ☐ Drop your Basic Life or Limited Basic Life coverage
- ☐ Add or increase your Supplemental coverage if you also have Basic Life
- ☐ Drop or decrease your Supplemental coverage
- ☐ Add or increase Supplemental coverage for family members (To do so you must have Basic & Supplemental Life)
- ☐ Drop or decrease Supplemental coverage for family members

Long Term Care insurance
(You can apply at any time, although you are only guaranteed coverage if you apply during the first 60 days you are eligible)

- ☐ Enroll in Long Term Care

Accidental Death & Dismemberment insurance

- ☐ Change beneficiary designation
- ☐ Add or increase your coverage
- ☐ Drop or decrease your coverage
- ☐ Add or increase family coverage
- ☐ Drop or decrease family coverage

Flexible Spending Accounts (By law, continuing participants must re-enroll every year)

- ☐ Enroll in Dependent Care Flexible Spending Account
- ☐ Enroll in Health Care Flexible Spending Account

Deferred Compensation Savings Plan
(Changes can be made at any time)

- ☐ Change beneficiary designation
- ☐ Enroll or increase contribution
- ☐ Stop or decrease contribution
- ☐ Add or increase Regular Catch-up contribution (for those within 3 years of retirement)
- ☐ Add or increase Age 50+ Catch-up contribution (for those who will be at least 50 on or before 12/31/2009.

Are Your Beneficiary Designations Current? To avoid problems should the unexpected happen, it is important to periodically review your beneficiary designations for insurance, retirement, deferred compensation and sick leave cash-out. Now is a good time for this review. Beneficiary updates made online during open enrollment become effective immediately.

Open Enrollment is Here!

Between **October 1 and October 30**, you can make changes to your benefits coverages and add or drop dependents (see checklist on preceding page). Make changes online through the Employee Self-Service portal or fill out forms and turn them in to your department HR representative **by October 30**. **Beneficiary updates made via Employee Self-Service are effective immediately**. Also remember that you must re-enroll if you wish to have a health care and/or dependent care Flexible Spending Account in 2009. Please **re-enroll** through Employee Self-Service. Even if you do not wish to make any changes, we encourage you to go on line and review/update your beneficiary information.

Increase in Age Limit for Dependent Children: A dependent child currently considered "over-age" may be eligible for health care coverage in 2009. Effective January 1 2009, the eligibility age limit for the medical, dental, and vision plans **will increase** to include dependent children up to age 25 (through age 24), regardless of whether they are in school. You **must re-enroll** your dependent child if he/she was not eligible at the end of 2008 under current rules and if he/she will be younger than 25 at least for part of 2009.

If you submit a paper enrollment form and then decide to make changes on line as well, be aware that the paper form you submit will be entered by your department's benefits representative after open enrollment is over. This means the changes on the paper form will take precedence over changes you make on line. Therefore, if you submit a paper form with changes and wish to make further changes, use another paper form with a later completion date.

Benefits Fairs

Flu shots will be available at all fairs.

- **Aetna Preventive and Group Health members** - shots are free at the Benefits Fairs when you bring your medical plan card (covered by your preventive care benefit under these plans).
- **Aetna Traditional members** may purchase flu shots for $30 by cash or check only.

Benefits Fairs Schedule

Downtown Fair **Wednesday, October 8** 9:30 a.m. - 2:30 p.m	City Hall - Bertha Knight Landes Conference Room 600 4th Avenue | 98104 (Enter at 5th and Cherry)
South Seattle Fair **Tuesday, October 14** 7:30 a.m. - 10:30 a.m.	Rainier Community Center 4600 – 38th Avenue South | 98118
North Seattle Fair **Thursday, October 16** 7:30 a.m. - 10:30 a.m.	Bitter Lake Community Center 13035 Linden Avenue North | 98133

In addition to the Benefits Fairs, flu shots will be offered at many City worksites. You will be notified of these additional locations.

Plan Changes

Medical Plan Changes Effective January 1, 2009

Aetna Preventive and Traditional

- **NEW BENEFIT — Add Simple Steps to a Healthier Life**

  Simple Steps to a Healthier Life is a new, voluntary and confidential wellness program to help you and your dependents age 18 or over determine your health risks now and plan for a healthier future. You may access the wellness program conveniently from work or home; there is no special software to buy or install. The registration process is quick, easy, and secure.

  The program provides a health assessment questionnaire to gauge your health risks, readiness to change certain health behaviors, and the impact of health on productivity. The health assessment questionnaire generates:

  - Tailored health reports to help you focus on the areas of your health that matter most. You also will receive a printable one-page health summary to keep, record, and compare your results over time and to share with your doctor, dentist, or other health-care provider.

  - An action plan that is personalized to help you achieve and maintain good health through healthy living programs that are recommended based on your health needs. These may address weight loss, healthy aging, getting in shape, stress relief, a healthier diet, a healthy heart, cancer fighting, diabetes fighting, going smoke-free, and/or alcohol awareness. The programs are easy to follow and provide step-by-step guidance for making health changes and building skills for long-term success. The programs also provide tools for tracking progress.

  Log into your account at www.aetnanavigator.com to access Simple Steps.

- **NEW BENEFIT — Add Personal Health Record**

  Your personal health record will provide you online access to personal information including individualized messages and alerts, detailed health history, and integrated information to help you make informed decisions about your health care. Your medical information is automatically entered into your record based on claims data submitted to Aetna. You may voluntarily enter additional health information such as family history, non-prescription medications, or procedures you had prior to Aetna membership.

  Log into your account at www.aetnanavigator.com to access your personal health record.

- **NEW BENEFIT — Add Informed Health Line Nurse Consultation**

  You will have 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of health topics. Learn about health conditions and medical procedures, or improve the way you communicate with your doctor.

  Call the Informed Health Line at 1-800-556-1555.

- **NEW ELIGIBILITY AGE LIMIT** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school.

- **NEW BENEFIT** – Jaw surgery exclusion removed. Medically necessary orthognathic surgery covered for correction of skeletal deformities of the jaw with required documentation.

- **ENHANCED BENEFIT** -- Eliminate the annual maximum benefit limit for durable medical equipment.

- **ENHANCED BENEFIT** -- Reduce annual pharmacy out-of-pocket maximum to $1,200 per individual, $3,600 per family.

- **NEW BENEFIT** – **Aetna Health Connections℠ disease management program**.

  Aetna Health Connections is a disease management program that will help individuals with chronic conditions. The program addresses 37 common chronic diseases and conditions such as hypertension, diabetes, low back pain, obesity, migraines, and asthma. Additionally, Aetna Health Connections nurses and clinicians can provide support if an individual suffers from more than one condition.

  Aetna Health Connections also provides added health protection. State-of-the-art technology is used to assess whether individuals are getting the right care and to let the participant and doctor know if there's a chance for better or safer care. The ActiveHealth® Management CareEngine® system continuously scans medical, laboratory and pharmacy claims and other clinical data, comparing participants' health data with current guidelines of care on over 1,000 conditions, identifying gaps, errors, omissions and duplications, and notifies the treating doctor about opportunities to improve care. It can identify potentially dangerous drug-drug interactions, drug-disease interactions and the need for preventive screenings or other care.

  Individuals may be identified for Health Connections participation through their physician or self-referral. A request may be submitted through the Aetna Navigator website, Aetna patient management staff, or by submitting medical or pharmacy claims data. Participation in the program is voluntary. Supported diseases and conditions in the Health Connections program are listed below:

Vascular	Pulmonary	Orthopedic	Oncology	Gastrointestinal	Neurological	Other
Congestive Heart Failure	Asthma (adult & children)	Osteoporosis	Breast cancer	GERD (gastro esophageal/ reflux disease)	Geriatrics	Obesity
Diabetes (adult & children)	Chronic obstructive pulmonary disease	Rheumatoid arthritis	Lung cancer	Peptic ulcer disease	Migraines	Chronic kidney disease
Coronary artery disease		Osteoarthritis	Lymphoma /leukemia	IBS Crohn's disease & ulcerative colitis	Seizure disorders	Sickle cell disease
Peripheral artery disease		Chronic low back pain	Prostrate cancer	Chronic hepatitis	Parkinsonism	Cystic fibrosis
Hypertension			Colorectal cancer			End-stage renal disease
Cerebrovascular disease/stroke			General cancer			Low back pain
Hyperlipidemia						HIV
						Hypercoagulable state

Group Health Standard and Deductible Plans

- **NEW ELIGIBILITY AGE LIMIT** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school.

Vision Plan Changes for 2009

Vision Service Plan

- **NEW ELIGIBILITY AGE LIMIT** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school.

Dental Plan Changes for 2009

Dental Health Services

- **NEW ELIGIBILITY AGE LIMIT** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school.

Washington Dental Service

- **NEW ELIGIBILITY AGE LIMIT** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school.

Flexible Spending Account Program Change for 2009

- **NEW BENEFIT** — Add use of debit card for health care flexible spending account (FSA) program. Use "reimbursement" at point of purchase.

  You may use the health care FSA to pay your non-reimbursed out-of-pocket expenses for medical, dental, prescription drug, vision and hearing services and supplies. Your before-tax contributions to your account through payroll deduction reduce your taxes and can be accessed currently to reimburse you after you incur eligible health care expenses.

  Effective January 2009, you will have a second way to access your health care FSA money. Both options will allow you to access your full annual contribution amount at any time for eligible expenses.

  1) Submit your itemized receipts and reimbursement form, as you do now, to Benefit Administration Company for reimbursement by check or direct deposit; and/or

  2) Request and use your new health care FSA debit card to purchase eligible health care items, thereby eliminating the need to request and wait for reimbursement. (Remember to retain all of your receipts.) You may obtain your debit card by contacting Benefits Administration Company starting the last week of December 2008 at 206-625-1800, extension 307 or emailing flexcs@baclink.com. Please allow 8 – 10 business days to receive your cards in the mail.

  Eligible health care expenses fall into two categories. Here are some examples:

  - The portion of covered expenses not paid by a health care plan, such as annual deductibles, co-pays, coinsurance, and covered charges that exceed the plan's annual maximum.
  - Services and supplies that may not be covered by the health care plan but are still considered an eligible expense by the IRS, such as hearing aid batteries, acupuncture, home improvements for medical reasons (e.g., wheelchair ramps, lowering of kitchen countertops), contact lens solution and laser vision correction.

  Expenses not eligible for reimbursement include health insurance premiums (already deducted on a pre-tax basis from your paycheck), vitamins, health club dues, and cosmetic surgery or treatments.

By law, if you participated in the dependent care and/or health care Flexible Spending Account program in 2008, you must re-enroll during Open Enrollment to participate in the 2009 program.

Enrollment Options

The plan and dependent coverage elections you make now are for the 2009 plan year. According to IRS Section 125 regulations, you cannot change your dependent election outside of open enrollment period unless you have a qualifying change in family status. Your enrollment options for 2009 and the consequences of your decision are described below.

ACCEPT medical coverage for yourself and eligible family members by completing and submitting a Health Care Benefit Election Form or making changes on line. If you do not fill out a new form or make changes on line, your plans will remain the same and you will pay the designated premium amount.

DECLINE medical coverage for yourself and/or family members (you may not decline dental or vision coverage).

- If you have no insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status as defined in the Change in Family Status/Dependent Eligibility section and enroll within the specified timeframes.
- If you have medical coverage elsewhere (you may not decline dental or vision coverage) and lose your other coverage, you may enroll in a City medical plan within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage.
- If you have a qualifying change in family status, you may enroll your eligible dependents within 31 days (or 60 days for a new child) of that change.
- If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical, dental, or vision coverage through the City under the federal COBRA law. However, if you retire you will be eligible to enroll in a City retiree medical plan.

Premium Sharing

The table below shows your premium contributions for 2009. Premium contributions will be divided into two equal payments and taken from the first two paychecks of the month before the actual month of coverage. (For example, premium contributions taken from your December paychecks are for January coverage.) Your premium contributions will be deducted on a pre-tax basis.

2009 Monthly Premiums for SPOG

Medical Plan	Employee's Premium Contribution	City-paid Premium Amount	Total Monthly Premium Amount
City of Seattle Preventive Plan	$52.99	$1007.09	$1060.08
City of Seattle Traditional Plan			
LEOFF I	$39.09	$742.98	$782.07
LEOFF II	$47.16	$896.18	$943.34
Group Health Standard Plan	$198.28	$793.12	$991.40
Group Health Deductible Plan	$36.56	$694.92	$731.48
Vision Service Plan	$0	$ 23.91	$23.91
Washington Dental Service	$0	$125.45	$125.45
Dental Health Services	$0	$152.19	$152.19

Domestic Partner/Same-Sex Spouse Taxable Values

Taxable Benefit Amount (Coverage Value)

If your domestic partner/same-sex spouse and/or his/her children do not qualify as your IRS tax dependents, you will be taxed on the **value** of their medical, dental and vision coverage as required by IRS regulations. The following amounts will be listed on your paycheck as taxable income and are subject to federal income and Social Security tax withholding. These values have been adjusted to reflect the premium amounts taken after-tax (as explained above) so you are not taxed twice.

2009 Monthly Taxable Values of City Benefits for Domestic Partners/Same-Sex Spouses		
Type of Coverage	**Domestic Partner/ Same-sex Spouse Taxable Value**	**Taxable Value Per Child**
Medical	$329.03	$147.01
Dental	$52.20	$27.76
Vision	$3.29	$1.47
Total Taxable Value	**$384.52**	**$176.24**

Changing Your Plan Choices Outside of Open Enrollment

You may only make changes to your benefits elections outside the open enrollment period, if family status changes occur in your family. The changes you can make depend on the status change. Call your department HR representative or the Central Benefits Unit (206-615-1340) for more information.

Changes in family status are defined as:

- Birth, adoption, placement of a child, or legal guardianship.
- Loss of a child, spouse, or domestic partner's eligibility under another health plan.
- Marriage or formation of a domestic partnership.
- Divorce, termination of a domestic partnership, or legal separation.

Eligible Dependents

You must be enrolled before you can enroll your dependents. Dependents eligible to be covered under the City's benefit programs are:

- Your spouse or domestic partner.
- Your biological or adopted children, children of your spouse or domestic partner, or any child for whom you are the legal guardian. The child must be unmarried and under age 25 regardless of whether he/she is in school.

Eligibility Age Limit Increase: A now over-age dependent child may be eligible again for health care coverage through you in 2009. Effective January 1, 2009, the eligibility age limit for the medical, dental, and vision plans will increase up to age 25 (through age 24), regardless of whether a dependent child is in school. You **must re-enroll** your dependent child if ineligible in 2008 and if he/she will be younger than 25 at least for part of 2009.

To cover a spouse/domestic partner, you must complete an Affidavit of Marriage/Domestic Partnership, available from your HR or Payroll Representative and on line at http://inweb/personnel/benefits/pubs/dp_affmarriage.doc. For dependent children, you may need to provide proof of legal guardianship.

If the premiums for a domestic partner or same-sex spouse are taken after taxes, you may drop a domestic partner or same-sex spouse at any time (without a change in family status) if he/she is not claimed as your IRS tax dependent.

Medical, Dental and Vision Coverage

Benefits Summaries

The following plan summaries will help you compare plan features and decide which plan best fits your needs. The summaries are not a complete description of benefits – see the plan booklets for exclusions, limitations and additional information. [1]

[1] If there is a discrepancy between the information here and in booklets, the booklet information will apply.

2009 Summary of Benefits—Seattle Police Officers' Guild (SPOG)

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (per calendar year)					
Does not apply	$200 per person $600 per family Except as noted, deductible applies to all services except rx, preventive care visits, ambulance service and durable medical equipment.	$100 per person $300 per family	$150 per person $450 per family	Does not apply	$250 per person, $750 per family
Annual Out-of-pocket Maximum (excluding deductible if applicable)					
$750 per person $1,500 per family	$2,000 per person $6,000 per family	$400 per person applies to 20% coinsurance. Most costs paid at 100% after out-of-pocket maximum is paid.	$1,600 per person applies to 40% coinsurance. Most costs paid at 100% of recognized charges* after out-of-pocket maximum is paid.	$500 per person $1,000 per family (applies to emergency room copays) Most costs paid at 100% after out-of-pocket maximum is paid.	$3,000 per person $6,000 per family Most costs paid at 100% of recognized charges* after out-of-pocket maximum is paid.
Maximum Lifetime Benefits Payable					
Combined $2,000,000 maximum for Standard and Deductible		Combined $2,000,000 maximum for Traditional and Preventive (in and out-of-network)			
Inpatient Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to specialists at GHC facilities.	All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to specialists at GHC facilities.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges.* You pay the difference between recognized charges and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges.* You pay the difference between recognized charges and billed charges.
COVERED EXPENSES					
Acupuncture					
Paid at 100%. 8 visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 100% after $20 copay. 8 visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay .	Paid at 70%
		Maximum of 12 visits per calendar year for in-network and out-of-network combined Maximum does not include acupuncture treatment for chemical dependency.			
Ambulance Service					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary		Paid at 100% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Deductible Plan	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Bariatric Surgery					
Limited coverage for morbidly obese adults. Surgery pre-authorization required.	N/A	N/A	N/A	N/A	N/A
Chemical Dependency Treatment (alcohol/drug addiction)					
Inpatient: Paid at 100% Outpatient: Paid at 100% Combined benefit maximum of $14,500 per 24 month period for inpatient and outpatient services	Inpatient: Paid at 100% Outpatient: Paid at 100% after $20 copay Combined benefit maximum of $14,500 per 24 month period for inpatient and outpatient services. Deductible applies.	Inpatient and Outpatient: Paid at 80% Combined benefit maximum of $14,500 per 24 month period for in-network and out-of-network services		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay Combined benefit maximum of $14,500 per 24 month period for in-network and out-of-network services	Inpatient: Paid at 70% Outpatient: Paid at 70%
Contraceptives					
Contraceptive drugs and devices: see Prescription Drug benefit.	Contraceptive drugs and devices see Prescription Drug benefit.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80%		Paid at 100%	Paid at 70%
Emergency Room Services					
GHC facility: Paid at 100% after $25 copay (waived if admitted) Non-GHC facility: Paid at 100% after $75 copay. (waived if admitted)	GHC facility: Paid at 100% after $75 copay (waived if admitted) Non-GHC facility: Paid at 100% after $125 copay (waived if admitted). Deductible applies.	Paid at 80% Urgent care paid at 100% after $35 copay	Paid the same as in-network, except if it's non-emergency use then 60% Urgent care paid at 60%	Paid at 100% after $50 copay (waived if admitted.) Urgent Care paid at 100% after $35 copay	Paid the same as in-network, except if it's non-emergency use then 70% after $50 copay (waived if admitted.) Urgent Care paid at 70%
Home Health Care					
Paid at 100% when authorized No visit limit	Paid at 100% when authorized No visit limit	Paid at 90% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.		Paid at 100% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	Paid at 70%
Hospice					
Paid at 100% when authorized.	Paid at 100% when authorized	Paid at 90%		Paid at 100% Maximum of 6 months for inpatient and outpatient combined. Additional 6 months available if authorized.	Not covered
Hospital Outpatient					
Covered in full.	$20 copay. Deductible applies.	Paid at 80% after satisfaction of deductible	Paid at 60% after satisfaction of deductible	Paid at 100% after satisfaction of deductible.	Paid at 70% after satisfaction of deductible.
Hospital Inpatient					
Covered in full.	Deductible applies	Paid at 80% after satisfaction of deductible.	Paid at 60% after satisfaction of deductible.	Paid at 100% after satisfaction of deductible.	Paid at 70% after satisfaction of deductible.

Maternity Care (Inpatient)					
Delivery & related hospital: Paid at 100%	Paid at 100%. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (Outpatient)					
Paid at 100%	Paid at 100% after $20 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Mental Health Care (Inpatient)					
No limit. Covered in full.	No limit. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Mental Health Care (Outpatient)					
No limit. Covered in full.	No limit. $20 copay. Deductible applies.	Paid at 50%.	Coinsurance does not apply to the annual out-of-pocket maximum	Paid at 100% after $5 copay	Paid at 70% Coinsurance applies to the annual out-of-pocket maximum.
Neurodevelopmental Therapy (for children under age 7)					
Covered under Rehabilitation benefit.	Covered under Rehabilitation benefit.	Outpatient: Paid at 80% Maximum of $2,000 per calendar year for in-network and out-of-network combined. Coinsurance does not apply to out-of-pocket maximum		Outpatient: Paid at 100% after $5 copay.	Paid at 70%. Coinsurance applies to annual out-of-pocket maximum.
				Maximum of $3,000 per calendar year for in- and out-of-network combined.	
Physician Services (Inpatient)					
Paid at 100%	Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Physician Services (Outpatient)					
Paid at 100% for most visits. No copay.	Paid at 100% after $20 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay per visit	Paid at 70%
Prescription Drugs (retail)					
For a 30 day supply: $3 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the out-of-pocket maximum.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the out-of-pocket maximum.	For a 34-day supply: Generic: $5 copay. Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units. Preferred brand-name: $10 copay Non-preferred drugs: $25 copay Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum.	Not covered	For a 31-day supply: Generic: $5 copay Preferred brand name: $10 copay Non-preferred drugs: $25 copay Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum.	Not covered

Prescription Drugs (Mail Order)					
Mailing service available, subject to a $3 copay per 30-day supply. Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: Generic: $30 copay Brand: $60 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: Generic: $10 copay Preferred brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered	For a 90-day supply: Generic: $10 copay Preferred brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered
Preventive Care					
Paid at 100% for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% after $20 copay. For preventive care visits, most immunizations, mammograms and eye exams not subject to deductible. Hearing exams are subject to deductible.	Paid at 80% for mammograms. Other preventive services not covered.	Paid at 60% for mammograms. Other preventive services not covered.	Paid at 100% for routine physical exams, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services are covered.
Rehabilitation Services (Inpatient)					
Paid at 100% Maximum of 60 days per calendar year for all types of rehabilitation.	Paid at 100%. Deductible applies. Maximum of 60 days per calendar year for all types of rehabilitation.	Paid at 80% Lifetime maximum of $50,000 per condition for in-network and out-of-network combined.	Paid at 60%	Paid at 100% Maximum of 120 days per calendar year for in-network and out-of-network combined.	Paid at 70%
Rehabilitation Services (Outpatient)					
Outpatient: Paid at 100% Maximum of 60 visits per calendar year for all types of rehabilitation.	Paid at 100% after $20 copay. Deductible applies. Maximum of 60 visits per calendar year for all types of rehabilitation.	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum. Maximum calendar year benefit of $2,000 for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $5 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Out-of-network coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits for each of the above listed benefits per calendar year for in-network and out-of-network combined.	Paid at 70%
Skilled Nursing Facility					
Paid at 100%; 60 day maximum per calendar year	Paid at 100%; 60 day maximum per calendar year. Deductible applies.	Paid at 80% Maximum of 90 days per calendar year for in-network and out-of-network combined.		Paid at 100% Maximum of 120 days per calendar year for in-network and out-of-network combined.	Paid at 70%
Smoking Cessation					
Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No copay for all smoking cessation prescription drugs.	Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No copay for all smoking cessation prescription drugs.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Not covered.	Not covered.

Spinal Manipulations					
Paid at 100% Self-referral to GHC designated providers. Must meet GHC protocol.	Paid at 100% after $20 copay. Deductible applies. Self-referral to GHC designated providers. Must meet GHC protocol.	Paid at 80%		Paid at 100% after $5 copay.	Paid at 70%
Maximum of 10 visits per calendar year.	Maximum of 10 visits per calendar year.	Maximum of 10 visits per calendar year for in-network and out-of-network combined.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.	
Sterilization Procedures					
Covered in full.	$20 copay. Deductible applies.	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%
Temporomandibular Joint (TMJ) Services					
Paid at 100% Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.	Inpatient: Paid at 100% Outpatient: Paid at 100% after $20 copay. Deductible applies. Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined. Deductible applies.	Not covered		Not covered	
Tooth Injury due to accident					
Not covered	Not covered	Paid at 80% Services of dentist or denturist covered based on recognized charges* up to 12 months from injury date to a maximum of $600. You pay the difference between recognized charges and billed charges. Physician and hospital benefits provided if inpatient care needed.		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay. *Services of dentist or denturist covered based on recognized charges up to 12 months from injury date. You pay the difference between recognized charges and billed charges. Physician and hospital benefits provided if inpatient care needed.	Paid at 70%
Travel Outside of Country					
Emergency: Paid at 100% after $75 copay. Waived if admitted. Non-emergency: Not covered Member must notify GHC within 24 hours of inpatient admission	Emergency: Paid at 100% after $125 copay. Waived if admitted. Non-emergency: Not covered Member must notify GHC within 24 hours of inpatient admission	Not applicable	Paid at 80% for an emergency. Paid at 60% for non-emergency.	Not applicable	Paid at 100% after applicable office, or emergency room copay. Paid at 70% after applicable copay for non-emergency.
Vision Exam & Hardware					
$100 per 24 month period. See details under "Vision Coverage" Coverage also provided under Vision Service Plan.	Exam: Paid at 100% after $20 copay at GHC. Coverage also provided under Vision Service Plan.	Covered under Vision Service Plan.		Covered under Vision Service Plan.	

Wellness Tools					
On line health profile to determine health risks. Health report and recommendations based on profile. Unlimited lifestyle coaching. Group Health Medical Records: All claims are included in the member's permanent record. Health profile data is integrated into the electronic medical record.		On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A
X-ray and Lab Tests					
Paid at 100%	Paid at 100%. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

*Applies to Aetna – Recognized charges are the lower of the provider's usual charge for performing a service, and the charge that Aetna determines to be the recognized charge percentage in the geographic area where the service is provided. **Full details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.**

2009 Summary of Dental Coverage

Dental Plan Comparison		
Plan Features	**Washington Dental Service (WDS)**	**Dental Health Services (DHS)**
Annual Deductible	$0	$0
Annual Maximum	$1500 person per year	No Annual Maximum.
Outpatient Copay	None	$5 copay per visit for the first three years of employment
Diagnostic and Preventive (routine and emergency exams, x-rays, cleaning, fluoride treatment, sealants)	Incentive payments levels 1st Year – 70% 2nd Year – 80% 3rd Year – 90% 4th Year – 100%	Paid at 100% Composite fillings for all teeth covered at no extra charge. Two additional cleanings for pregnant women, up to four cleanings.
Crowns, Inlays, Onlays	Paid at incentive levels shown above	Paid at 100% Extra charge for noble/high noble metals ($50 noble, $80 high noble, $125 charge on upgraded, specialized porcelain)
Prosthodonic Services	Paid at 50%	Paid at 100%
Dentures, Bridges		
Orthodontia	Paid at 50% Provides coverage for Adult and Child orthodontia with a $2,000 lifetime maximum. Benefits provided for eligible employees, spouse/partner, and dependent, unmarried children under age 25 (through 24) regardless of whether they are in school.	$400 copay. $150 pre-orthodontic service copay, which includes: Initial orthodontic exam $25 Study models/x-rays $125 Benefits provided for eligible employees, spouse/partner, and dependent, unmarried children under age 25 (through 24) regardless of whether they are in school.
Lifetime Maximum	$2,000	N/A
Choice of Providers	In-Network: Any contracted provider. Out-of-Network: Any licensed, qualified provider of your choice.**	In-Network: Any contracted provider in the DHS network. Out-of-Network: No out-of-network coverage.
Periodontics (surgical and nonsurgical procedures for treatment of the tissues supporting the teeth)	Paid at incentive levels above	Paid at 100%
Oral Surgery (routine and surgical extractions)	Paid at incentive levels above	Paid at 100%
Temporomandibular Joint (TMJ) Disorders	Not covered	$1,000 annual max $5,000 lifetime max
Dental Implants	Paid at 50%	Discounted implants are available. Call 877-495-4455 for information and costs.
Other	N/A	Occlusal (night guard) with $350 copay.

** Expenses paid based on actual charges or average fee charged by 51% of providers in the area, whichever is less.
Note: This summary is not all-inclusive. See the Benefits Booklets for each plan for additional information.

2009 Summary of Vision Coverage

Vision Service Plan: Eye exams, prescription lenses, frames and contacts are available through Vision Service Plan (VSP). You may use VSP doctors or out-of-network providers. To obtain the names of VSP doctors in your area, visit www.vsp.com or call 1-800-877-7195.

A summary of your vision and eyewear benefits is provided below. A 20% discount applies to the purchase of additional complete pairs of glasses, including prescription sunglasses, obtained from the same VSP doctor within 12 months of your last eye exam.

VSP also provides you with the flexibility to choose contact lenses instead of glasses. You'll receive a 15% discount off the cost of the contact lens exam from a VSP doctor. VSP also offers savings on annual supplies of certain brands of contacts. You can receive these member-preferred prices, even if you use your coverage for glasses. Visit www.vsp.com or ask your doctor for details.

2009 Summary of Vision Coverage

Plan Features	VSP Provider	Non-VSP Provider
Eye exam Covered each calendar year.	$10 copay (copay also covers prescription lenses and frames)	$10 copay (copay also covers prescription lenses and frames) Up to $40 for exam only.
Prescription Lenses and Frames Covered every calendar year in lieu of contact lenses.	$10 copay. (Copay also covers exam). Complete prescription glasses and special lens options discounted by 20% and covered up to $200 of retail cost.	$10 copay. (Copay also covers exam). Up to $200 of retail cost.
Elective contacts Covered every calendar year in lieu of lenses and frame.	Covered up to $200 of retail cost and 15% discount on covered materials and professional services (eye exam covered under eye exam benefit with copay).	Up to $200 of retail cost.

Vision coverage is also included in the Group Health Plans

The Deductible plan pays for an exam only (after a $20 copay).

The Standard plan offers a routine eye examination and a benefit of $100 per 24 month period for hardware. Benefits may be used toward the following in any combination, during the benefit period, until the benefit maximum benefit of $100 per 24 month period is exhausted.

- Eyeglass frames
- Eyeglass lenses (any type) including tinting and coating
- Corrective industrial (safety) lenses
- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity
- Corrective contact lenses in the absence of eye pathology (disease of the eye), including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

The benefit period begins on the date the glasses or contact lenses are ordered and continues for consecutive 24 months.

Contact lenses for eye pathology, including following cataract surgery, are covered in full except as explained above.

Exclusions: Evaluation and surgical procedures to correct refraction, which are not related to eye pathology, are not covered. Complications directly related to this type of surgery would also not be covered.

Flexible Spending Accounts

The City offers two kinds of flexible spending accounts (FSA) – health care and dependent care.

Health Care Flexible Spending Account (FSA)

You may set aside from $300 to $5,000 of pre-tax earnings annually to pay for out-of-pocket expenses such as dental/orthodontia care not covered by the dental plan; medical, dental and vision copays, deductibles, coinsurance; eye wear, massages, or any IRS-eligible health care expense. Amounts set aside in the health care FSA reduce your taxes.

Here is how the Health Care FSA Plan works:

- You select the amount per month you wish to set aside as a payroll deduction, which may not exceed $416 per month or $5,000 per year.
- The amount you select is deducted from your paycheck BEFORE federal income and Social Security taxes are taken out.
- As you incur eligible expenses, you:
    - Submit your itemized receipts and reimbursement form, as you do now, to the City's FSA plan administrator (Benefits Administration Company) for reimbursement by check or direct deposit; and/or
    - Use your health care FSA debit card to purchase health care items, while retaining all your receipts.
- You must sign up for the health care FSA to participate in the program and **re-enroll each year** during open enrollment. Even if you are participating this year, you must re-enroll to participate in 2009.
- In order to receive an FSA debit card for 2009, call Benefits Administration Company at 206-625-1800, extension 307 or email flexcs@baclink.com starting the **last week of December 2008**. The card will arrive in 8 – 10 business days by U.S. mail.
- Your dependents' health care expenses are also eligible for reimbursement. (Domestic partners/same-sex spouses and their children must meet the IRS eligibility criteria for dependents.)

Dependent Care (Day Care) Flexible Spending Account (FSA)

The City offers the Dependent Care FSA to help make day care expenses more manageable. By using the dependent care FSA to pay for care for children under age 13 or any other person who qualifies as a dependent if he or she is physically or mentally incapable of self-care, you can reduce your taxes. (Please refer to IRS Publication 503 for eligible dependent care expenses.) Here's how it works:

- Set aside earnings each month on a pre-tax basis through payroll deduction to pay for planned dependent care expenses. Contribute as little as $25 a month or as much as $416 a month ($5,000 maximum per family).
- The amount you select is deducted from your paycheck BEFORE federal income and Social Security taxes are taken out.
- When you have an eligible dependent care expense, you submit an invoice or a paid receipt to Benefits Administration Company and are reimbursed for the expense after services are provided, up to the amount currently in your account.
- You must **re-enroll** each year during open enrollment to participate the following year.

For more information go to http://inweb/personnel/benefits/flex.asp. A form is included at the back of this booklet.

Optional Insurance Plans

Long Term Disability (LTD)

As part of your basic City benefits package you receive a Basic Long Term Disability policy that will pay a portion — 66% of the first $667 in base earnings or up to $400/month — of your monthly pay if you are sick or injured and cannot work. If you are disabled according to the definition in the plan, the plan benefit will combine with other sources of income to pay you up to $400 per month after a 90-day waiting period. Your basic benefit maximum will be up to $400 per month while you are unable to work.

Supplemental LTD

You may add to your Basic LTD coverage during open enrollment by purchasing Supplemental LTD coverage. The Supplemental LTD plan will combine with other income sources to provide 60% of your monthly base pay over $667 (up to a maximum of $8,333 monthly base pay) for a total benefit of up to $5,000 per month.

If you are currently eligible to receive a retirement benefit from the City if you were to leave employment, you may not want to purchase this coverage because the maximum LTD benefit you would receive would be $100 per month if you elect to receive a retirement pension.

How Much will Supplemental LTD Coverage Cost?
The cost for this additional level of earnings protection is figured according to the following formula:
1. Subtract $667 from your base monthly pay.
2. Multiply the remaining amount by .0075.
For example, if your base pay is $2,000 per month, your monthly premium would be $9.99/month ($2,000 - $667 = $1,333 x .0075 =$9.99/month). Your monthly cost increases each time your pay increases.

Group Term Life (GTL) Insurance

Benefit choices include three levels of optional term life insurance: Basic GTL, Limited Basic GTL, and Supplemental GTL. The City and you pay for Basic GTL or Limited GTL, while you pay the full cost for any Supplemental Life Insurance. The Group Term Life Insurance Election Form is on the Personnel Department InWeb site at http://inweb/personnel/pubs/benefits.asp#life, or available from your Human Resources Representative.

Basic Term Life Insurance

This optional coverage provides you with a term life benefit amount equal to 1.5 times your annual salary. The City contributes 40% of the cost and you pay the other 60%.

Your coverage amount is equal to your annual salary, rounded up to the next $1,000 increment, multiplied by 1.5. Your monthly premium equals $0.081 times each $1,000 of coverage. For example, if your salary is $25,500, round it up to $26,000. Your coverage amount is $39,000 (Calculation: $26,000 x 1.5 = $39,000). Your premium is $3.16 per month (Calculation: $0.081x 39)

Remember, if you are not a new employee, but you want to apply for Basic Group Term Life Insurance during open enrollment, you must complete a Medical History Statement and return it with your Group Term Life Insurance Election Form. Medical History Statements are available from your Department's Human Resources Representative or the Benefits Unit.

Limited Basic GTL:

IRS rules state that the value of any Basic Life Insurance over $50,000, which is paid for by the City, is taxable. The value depends on your age (and associated risk of death) and the amount of the coverage. Because the

City pays 40% of the cost for your Basic GTL, you may have some taxable value. If you do, the amount on which you pay taxes will be shown on your second paycheck stub each month under the section titled "Other Benefits and Information." To avoid the additional taxes, you may limit your Basic GTL coverage to $50,000 by signing a notarized Waiver form and completing and submitting it and the Group Term Life Insurance Election Form to your department's Human Resources Representative. Both forms are available at the Personnel Department InWeb site at http://inweb/personnel/pubs/benefits.asp#life and http://inweb/personnel/benefits/pubs/gtl_waiver.pdf or from your department's Human Resources Representative.

The following table shows the monthly cost of Basic GTL insurance and the amount you are eligible to buy based on annual earnings.

Annual Earnings	Monthly Cost	Amount of Insurance
49,000.01 – 50,000	6.08	75,000
50,000.01 – 51,000	6.20	76,500
51,000.01 – 52,000	6.32	78,000
52,000.01 – 53,000	6.44	79,500
53,000.01 – 54,000	6.56	81,000
54,000.01 – 55,000	6.68	82,500
55,000.01 – 56,000	6.80	84,000
56,000.01 – 57,000	6.93	85,500
57,000.01 – 58,000	7.05	87,000
58,000.01 – 59,000	7.17	88,500
59,000.01 – 60,000	7.29	90,000
60,000.01 – 61,000	7.41	91,500
61,000.01 – 62,000	7.53	93,000
62,000.01 – 63,000	7.65	94,500
63,000.01 – 64,000	7.78	96,000
64,000.01 – 65,000	7.90	97,500
65,000.01 – 66,000	8.02	99,000
66,000.01 – 67,000	8.14	100,500
67,000.01 – 68,000	8.26	102,000
68,000.01 – 69,000	8.38	103,500
69,000.01 – 70,000	8.51	105,000
70,000.01 – 71,000	8.63	106,500
71,000.01 – 72,000	8.75	108,000

Supplemental Group Term Life Insurance (GTL)

The City offers Supplemental GTL as an additional option for term life insurance. As long as you are enrolled for Basic GTL, you may purchase this additional term life insurance for yourself and eligible family members. You pay the entire cost for Supplemental GTL coverage. In order to cover your family members, you must enroll yourself, subject to various election rules.

- You may purchase Supplemental GTL for yourself up to 4 times your base salary. The coverage amount is rounded down to the nearest $5,000. For example, if your salary is $34,000 and you purchase one times your base salary, your actual coverage amount is $30,000. If the amount of Supplemental GTL when added to the amount of your Basic GTL would exceed $500,000 you will need to complete and submit a Medical History Statement.
- To elect life insurance for your family members, you must be enrolled or have applied for Supplemental GTL.
- You may purchase Supplemental GTL for your spouse/domestic partner in multiples of $5,000 up to a maximum of 50% of the amount of Supplemental GTL coverage you purchase for yourself. For example, if

you purchase $120,000 of Supplemental GTL for yourself, you may purchase up to $60,000 of Supplemental GTL for your spouse/domestic partner.

- You may purchase Supplemental GTL for your children equal to $2,000, $5,000 or $10,000 for each child. Children may be covered until their 25th birthday.

Costs for Supplemental GTL for you and your spouse/domestic partner are based on your age (and associated risk of death) and the amount of coverage. Costs for covering eligible children are fixed and the monthly premium is the same regardless of how many children you cover.

Rules for Electing Life Insurance

1. Unless you are a new employee, if you sign up for Basic and/or Supplemental GTL during this open enrollment period, you will need to complete and submit a Medical History Statement. To elect life insurance for your family members, you must be enrolled or have applied for Supplemental GTL.
2. If you want to purchase Supplemental GTL for your spouse/domestic partner, he/she will also need to complete and submit a Medical History Statement. If you are a new employee, a Medical History Statement is required for your spouse or domestic partner only for coverage in excess of $50,000.
3. If you want to purchase Supplemental GTL for your child(ren), no Medical History Statement is needed.

Supplemental Group Term Life Insurance
2009 Monthly Cost to Employees

Supplemental GTL for Employee and Spouse/Domestic Partner		**Supplemental GTL for Children (cost includes all children)**	
Your Age	**Monthly cost/$1,000**	**Amount of coverage**	**Monthly cost**
18-29	$.032	$2,000	$ .40
30-34	$.048	$5,000	$1.00
35-39	$.064	$10,000	$2.00
40-44	$.090		
45-49	$.152		
50-54	$.232		
55-59	$.360		
60-64	$.552		
65 & over	$.960		

Accidental Death and Dismemberment (AD&D) Insurance

To supplement your Basic and Supplemental Life Insurance, you may purchase AD&D Insurance for yourself, your spouse/domestic partner, and/or children. You can add or change your AD&D coverage by completing and submitting an AD&D Insurance Election Form or making the changes on line. The form is available at the Personnel Department InWeb site at http://inweb/personnel/benefits/pubs/addltd.doc, or from your Human Resources Representative.

Employee Only Coverage
You can cover yourself for amounts from $25,000 to $500,000 (in $25,000 increments). AD&D Insurance pays a death benefit (full insurance amount or "principal sum") if the insured person dies due to an accident or a percentage of the principal amount if the covered person loses a limb(s) due to an accident. For example, a person who is covered by AD&D Insurance would receive 50% of the full insurance amount if he/she lost a limb from an injury relating to an accident.

Family AD&D Coverage
If you elect Family AD&D coverage, the amount of coverage for your covered dependents/domestic partner is a percentage of your coverage amount as shown below:

Coverage when Dependents include:	Spouse/ Partner coverage amount	Each Child's coverage amount
Spouse/DP Only	60%	0%
Spouse/DP & Children	50%	15%
Children Only	0%	20%

AD&D Coverage Costs

This chart shows the monthly costs for AD&D coverage for employee and family coverage.

Accidental Death & Dismemberment Insurance 2009 Monthly Cost to Employees					
	YOUR MONTHLY COST			**YOUR MONTHLY COST**	
Principal Sum:	**Employee Only:**	**Employee and Family**	**Principal Sum:**	**Employee Only:**	**Employee and Family**
$ 25,000	.38	.63	275,000	4.13	6.88
50,000	.75	1.25	300,000	4.50	7.50
75,000	1.13	1.88	325,000	4.88	8.13
100,000	1.50	2.50	350,000	5.25	8.75
125,000	1.88	3.13	375,000	5.63	9.38
150,000	2.25	3.75	400,000	6.00	10.00
175,000	2.63	4.38	425,000	6.38	10.63
200,000	3.00	5.00	450,000	6.75	11.25
225,000	3.38	5.63	475,000	7.13	11.88
250,000	3.75	6.25	500,000	7.50	12.50

Where to Find More Information about Your Benefits

- You can check your current benefits elections on line if you have access to Employee Self Service on the City's InWeb. Go to http://selfservice . Benefit elections are under the Benefits Menu. If you do not have access to the InWeb, contact your department's Human Resources Representative.
- The Personnel Benefits website provides coverage summaries and informational booklets, as well as websites and contact information for each plan. Go to http://inweb/personnel/benefits
- You can access Aetna's custom DocFind website for City of Seattle at http://www.aetna.com/docfind/custom/cityofseattle
- Aetna Navigator (www.aetnavigator.com) is a personalized website packed with health and provider information. Once you have registered, you can check the status of your claim, view Explanation of Benefits (EOB) statements, find a doctor or pharmacy, compare hospitals, price a prescription drug, sign up for the mail order drug (MOD) program, and refill MOD prescriptions. You can access the site 24 hours a day, 7 days a week.
- You can access Group Health's website at www.ghc.org and register for MyGroupHealth. Once you've registered, you can send a secure e-mail to your health care team, refill prescriptions and get drug information, make appointments, access a huge database of health information, use health risk assessment and improvement tools, and find facility and service information.

Who to Contact if You Have a Question

If you have questions, contact the following organizations by phone or obtain information through their web sites. The Personnel Department's Central Benefits Unit can be reached at 206-615-1340.

Aetna	877-292- 2480	www.aetnanavigator.com
Group Health Cooperative	888 901-4636	www.ghc.org
Vision Service Plan	800- 877-7195	www.vsp.com click on "Members and Consumers"
Washington Dental Service (WDS)	206-522-2300 or 800-554-1907	www.ddpwa.com
Dental Health Services	206-788-3444 877-495-4455	www.dentalhealthservices.com/cityofseattle
Prudential Retirement Bill Miller	800-833-5761 206-447-1924	www.prudential.com/online/retirement
Employee Assistance Program	206-654-4144 or 800-553-7798	http://www.eapfs.com Click on "I am an Employee" Username: "City of Seattle"
Long-Term Care John Hancock Insurance	800-439-3030	www.cityofseattle.jhancock.com User name: cityofseattle Password: mybenefit
Life, AD&D, LTD		Your Department/HR Representative
Health/Dependent Care Flexible Spending Accounts	206-625-1800 800-967-3709 FAX: 206-682-8016	Benefit Administration Company www.benefitadministrationcompany.com

SPOG 2009 OPEN ENROLLMENT
HEALTH CARE BENEFIT ELECTION FORM

Last Name (Please Print)	First Name	Employee Number	Department

Home Address – Street	City	State	Zip

Hire Date	Work Phone	Birth Date (M/D/Y)	Social Security Number
			- -

MEDICAL, DENTAL and VISION INSURANCE

Effective date of coverage/change is **January 1, 2009** for:

☐Adding dependent(s) ☐Dropping dependent(s) ☐ Plan Change

Medical Plan Selection	**Employee Premium Share**
☐ City of Seattle Preventive Plan	
☐ LEOFF I and II Employee (and dependents, if any)	$52.99
☐ City of Seattle Traditional Plan	
☐ LEOFF I Employee (dependents only)	$39.09
☐ LEOFF II Employee (and dependents, if any)	$47.16
☐ Group Health Standard Plan	
☐ LEOFF I and II Employee (and dependents, if any)	$198.28
☐Group Health Deductible Plan	
☐ LEOFF I and II Employee (and dependents, if any)	$36.56
Vision Plan	
☐ Vision Service Plan	None
Dental Plan Selection	
☐ Dental Health Services	None
☐ Washington Dental Service	None

Add Dependent Coverage Information: List all eligible dependents to be included. Attach list for any additional dependents.

Spouse/Domestic Partner — **Birth Date** — **Enroll In**

							☐**Yes** ☐ **No**	☐**Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

☐ **Spouse** ☐ Male ☐ Female **OR** ☐ **Domestic Partner** ☐ Male ☐ Female | Partner claimed as IRS tax dependent ☐Yes ☐ No

1. Dependent Child — **Birth Date** — **Enroll In**

							☐**Yes** ☐ **No**	☐**Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐Yes ☐ No **OR** **Other** (Step-child or Legal Guardian) ☐Male ☐ Female

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED ON THE REVERSE SIDE

2. Dependent Child **Birth Date** **Enroll In**

							☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐ Yes ☐ No **OR** **Other** (Step-child or Legal Guardian) ☐ Male ☐ Female

3. Dependent Child **Birth Date** **Enroll In**

							☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐ Yes ☐ No **OR** **Other** (Step-child or Legal Guardian) ☐ Male ☐ Female

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Dependent Eligibility Information: If you have listed a dependent child under the age of 25 years, please answer the questions below about your dependent:

1. Married? ☐ Yes ☐ No
2. Income tax dependent? ☐ Yes ☐ No
3. Incapacitated or Disabled? ☐ Yes ☐ No

Coverage Options

☐ **I ACCEPT COVERAGE**

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

_____ _____

Employee's signature Date

☐ **I DECLINE COVERAGE**

If you have medical coverage elsewhere and lose your other coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you have a qualifying change in family status, you may enroll within 31 days (or 60 days for a new child) of that change. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law through the City. However, if you retire you will be eligible to enroll in a City retiree medical plan.

If you decline coverage and have no medical insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law or enroll in a City retiree medical plan.

I understand that by declining City of Seattle medical insurance, my medical coverage through the City will end, but my vision and dental insurance will continue.

I decline medical coverage for myself and family members.

_____ _____

Employee's signature Date

Department Representative's signature_____ Date Entered into HRIS _____

CITY OF SEATTLE

Accidental Death and Dismemberment (AD&D) and Supplemental Long-Term Disability (LTDS) Insurance Election Form

Last Name (Please Print) | First Name | Employee Number | Department

Home Address – Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

ACCIDENTAL DEATH & DISMEMBERMENT

Effective date of coverage/change _____ for: ☐ Adding coverage ☐ Canceling coverage
☐ Changing principal sum ☐ Changing type of coverage (individual or family) ☐ Changing beneficiary

☐ **YES,** I am applying for accidental death and dismemberment insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

☐ **Individual** ☐ **Family** **Principal Sum $** _____

BENEFICIARY: Specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, please use a separate list, sign, date, and attach to form.

Last Name (Please Print) | First Name | Address | _____ % of Benefit ☐ Check if Contingent

Last Name | First Name | Address | _____ % of Benefit ☐ Check if Contingent

Last Name | First Name | Address | _____ % of Benefit ☐ Check if Contingent

☐ **NO,** I do not wish to purchase accidental death and dismemberment coverage at this time. I understand that if I later want coverage, I may only enroll during an open enrollment period.

SUPPLEMENTAL LONG TERM DISABILITY

Effective date of coverage/change _____ for:
☐ New employee ☐ Adding supplemental coverage ☐ Canceling supplemental coverage

☐ **YES,** I am applying for Supplemental Long Term Disability insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. I understand that my coverage will be subject to any applicable pre-existing condition exclusions. This coverage is in addition to the Basic LTD coverage provided by the City. **Enrollment in this insurance is mandatory for LEOFF II Police and Fire employees.**

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental Long Term Disability insurance plan. I understand that if I enroll later during an open enrollment period, my insurance will be subject to a longer pre-existing condition exclusion. I also understand that Basic LTD will still be provided by the City even if I do not elect Supplemental LTD coverage.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carriers to obtain, examine or release information needed to process claims for myself or my family.

Employee's signature_____ Date_____

Department Representative's signature_____ Date Entered into HRIS_____

City of Seattle
GROUP TERM LIFE INSURANCE ELECTION FORM

Last Name (Please Print) | First Name | Employee No. | Department

Home Address - Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

BASIC GROUP TERM LIFE INSURANCE

Effective date of coverage/change _____ for: ☐ New Employee ☐ Adding coverage ☐ Canceling coverage

☐ **YES**, I am applying for group term life insurance according to the terms of the group policy issued to the City of Seattle, with coverage equaling 1½ times my annual salary. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

☐ **NO,** I do not care to participate in the City of Seattle's group term life insurance plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

BASIC GROUP TERM LIFE INSURANCE -- LIMITED COVERAGE

Effective date of coverage/change _____ for: ☐ New Employee ☐ Adding coverage ☐ Canceling coverage

☐ My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle. I authorize premiums to be deducted from my salary. Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election. I understand if I later want to increase my GTL coverage amount, I will be required to provide a Medical History Statement. My signed and notarized *Waiver Agreement* accompanies this application.

SUPPLEMENTAL GROUP TERM LIFE INSURANCE -- INDIVIDUAL COVERAGE

Effective date of coverage/change _____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for myself in the following amount according to the terms of the group policy issued to the City of Seattle. The coverage amount selected below does not exceed four times my annual salary rounded to the next lower multiple of $5,000 if not already a multiple of $5,000. ***I understand this coverage can only be purchased if I have also elected Basic GTL or Basic GTL - Limited Coverage***. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

Coverage Amount: $ _____ **Current Annual Salary: $** _____

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental GTL plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

SPOUSE OR DOMESTIC PARTNER COVERAGE

Effective date of coverage/change _____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my spouse/domestic partner in the amount of **$** _____ according to the terms of the group policy issued to the City of Seattle. **This coverage amount is at least $5,000 or a multiple of $5,000, and is *not greater* than 50% of my Individual Supplemental GTL coverage amount.** I understand this coverage can only be purchased

if I have also elected Individual Supplemental GTL coverage, and benefits for any loss are payable to me. I authorize deductions from my salary for contributions I am required to make toward the cost of this insurance.

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for a spouse or partner. I understand that if I currently have a spouse or partner, s/he will be required to submit a Medical History Statement if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

DEPENDENT CHILD COVERAGE

Effective date of coverage/change _____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my child(ren) or my spouse's/domestic partner's child(ren) in the amount selected below according to the terms of the group policy issued to the City of Seattle. I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, covered child(ren) must meet the eligibility criteria, and benefits for any loss are payable to me. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (One amount covers all children)

☐ **$2,000** ☐ **$5,000** ☐ **$10,000**

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for dependent children. I understand that if I currently have a dependent child(ren), I may apply for coverage later only during an annual open enrollment period.

BENEFICIARY INFORMATION

Effective date of beneficiary change

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
			% of Benefit ☐ Check if Contingent
Last Name	First Name	Address	

Beneficiaries for Supplemental Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
			% of Benefit ☐ Check if Contingent
Last Name	First Name	Address	

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's signature _____ Date_____

I have completed and mailed the required Medical History Statement to the insurance company because:

☐ I am not a new employee and I am applying during open enrollment.
☐ I am not a new employee and I am applying for Spouse or Domestic Partner coverage during open enrollment.
☐ I am a new employee and the combined total of my Basic and Supplemental coverage exceeds $500,000.
☐ I am a new employee and the Supplemental coverage for my spouse/domestic partner exceeds $50,000.

Department Representative's signature_____ Date Entered into HRIS_____

CITY OF SEATTLE 2009 FLEXIBLE SPENDING ACCOUNT ENROLLMENT AND SALARY AGREEMENT FORM

Last Name (Please Print) First Name | Department | Bargaining Unit | Employee No.

Home Address - Street | City, State, Zip | Work Telephone

☐ **Health Care FSA**
Medical, Dental and Vision expenses not covered by your insurance plans

☐ **Dependent Care (Day Care) FSA**
Day Care expenses for eligible dependents

Health Care Flexible Spending Account Contribution Amount	**Dependent Care (Day Care) Flexible Spending Account Contribution Amount**
The minimum amount you can contribute is $25 each month (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(This amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.	The minimum amount you can contribute is $25 each month (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(This amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.
Deduction Schedule	**Deduction Schedule**
I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**	I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**
For 2009, this is a ☐ new enrollment ☐ re-enrollment	For 2009, this is a ☐ new enrollment ☐ re-enrollment

Note: This form is not valid unless signed on Page 2 – see reverse side.

Signature

My signature below indicates that I have read the enrollment form and descriptive materials, including the plan document, covering the Health Care and/or Dependent Care Flexible Spending Account programs provided by the City of Seattle. This enrollment form is binding on me and cannot be revoked or modified (other than as explained in the materials provided). I also understand that my salary will be reduced by the amount I have elected, that salary deductions occur twice a month (with no deductions on the third paycheck), and that any amount left in my FSA account after all 2008 claims have been paid will be forfeited.

I also understand that this arrangement for paying eligible expenses with nontaxable dollars is intended to meet Internal Revenue Service requirements for such arrangements. If tax laws change or if this arrangement is deemed not to satisfy the requirements, I understand that the tax advantages described may not be available. I acknowledge that the City of Seattle makes no guarantee concerning the availability of any tax advantage.

Participant's Signature _____ Date _____

Please Forward this Form to the Benefits Representative in <u>Your Department</u>

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SEATTLE, WA
PERMIT # 1046

City of Seattle

Personnel Department
Benefits Unit
700 Fifth Avenue, Suite 5500
P.O. Box 34028
Seattle, WA 98124-4028

RETURN SERVICE REQUESTED

Open Enrollment for Plan Year 2009
October 1 to October 30, 2008

IMPORTANT: Change forms and Flexible Spending Account enrollment forms are due to your Department Human Resources representative by October 30. You can also enroll on line.